2007 UBO/UBU Conference

From Registration to Accounts Receivable – The Whole Can of Worms

Briefing: 2007 CPT/HCPCS Coding Changes for the Military Health System

Date: 20 March 2007

Time: 1300 - 1350

Objectives

- By the end of this briefing, you will be able to:
  - List the code groups which will have the greatest change on MHS coding
  - Understand why various codes were added, deleted, and changed

When to Run, When to Sit Tight

- MHS Relative Value Units (RVUs) for new CPT/HCPCS are assigned in May, and applied for the entire calendar year
- Rates for new CPT/HCPCS codes are usually available in June of that year, and not applied retroactively
- CMS does not have a 90-day conversion window, but most other insurance companies do, so if code conversion is delayed, and 2006 codes are used in 2007, many insurers will pay

When to Run, When to Sit Tight

- BOTTOM LINE: Strongly **recommend** you
  - Load the new MHS tables in CHCS and ALHTA at the same time, AND
  - Don't load the new 3M tables in CCE until you load the new 2007 CPT/HCPCS in CHCS (ADM) and AHLTA

Level II National Codes

- HCPCS National Level II codes are alphanumeric codes that start with a letter followed by four numbers
- The range of HCPCS National Level II codes is from A0000 through V0000
- There is some overlap among the three HCPCS code levels.
- There may be times when a code exists at all three levels for the same service or material

What's the rule?

Local Level II codes have the highest priority — followed by CPT codes

Instructions — HCPCS National Level II Codes

- A health care professional selects the name of the material, supply, injection, service, or procedure that most accurately identifies the service performed or supply delivered
- HCPCS codes are used instead of — or in addition to — CPT codes for visits, evaluation and management services, or other procedures performed at the same time or during the same visit
- All services, procedures, supplies, materials, and injections should be properly documented in the medical record

Code Groups with the Greatest Change on MHS Coding

- Long-term Anticoagulant Monitoring
- Emergency Room Institutional
- Regional Anesthesia
- Office and Ambulatory Procedure Visits

Anticoagulation Management

Not to be reported if patient managed by outpatient pharmacist or nurse anticoagulation clinic. If nurse or outpatient pharmacist, continue to use S9401, for which we assigned RVUs last year

- International Normalized Ratio (INR) tests – standards of care basis (initial is 8, subsequent is 3)
- May not report work or time twice

Anticoagulation Management

- **99363** Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; initial 90 days of therapy (must include a minimum of 8 INR measurements)

- **99364** Each subsequent 90 days of therapy (must include a minimum of 3 INR measurements)

Anticoagulation Management

- Example: Established patient newly diagnosed with congestive heart failure (super secret category II code abbreviation “HF”) and paroxysmal or chronic atrial fibrillation. Patient was prescribed warfarin therapy
  - This visit, code the E&M based on documentation. Consider using the CPT category II 4012F “Wafarin therapy prescribed” so you can easily tell when the “90-day clock” starts running
- Patient seen for other stuff during the next 90 days. Do not include the anticoagulation management documentation in the E&M determination
- Patient seen at day 95 and has 8 International Normalized Ratio (INR) testing, adjustments, etc., documented over the past 95 days. Code the E&M of the current visit based on non-anticoagulation management documentation, with modifier 25. Code the 99363 as an E&M

Emergency Department Institutional

- Until now, there were codes for
  - The professional component of an Emergency Department visit (99281-99285)
  - The professional and institutional components of procedures (for any procedure considered an outpatient procedure)
- But, no number to code separately the institutional component of the Emergency Department visit

Emergency Department Institutional

Examples

- "Normal adult patient" reports with laceration. Code minor professional component (99281) and suture
- "High-on-who-knows-what-combative-patient" brought in by authorities (who have another call and leave) with laceration. Code minor professional component (99281) and suture
  - No way to indicate it took two technicians to hold the patient for 15 minutes while the nurse tried to clean the wound prior to the doctor doing the suturing, in all an additional 45 minutes of staff time

Emergency Department Institutional

G0380		LEV 1 HOSP TYPE B ED VISIT
G0381		LEV 2 HOSP TYPE B ED VISIT
G0382		LEV 3 HOSP TYPE B ED VISIT
G0383		LEV 4 HOSP TYPE B ED VISIT
G0384		LEV 5 HOSP TYPE B ED VISIT

- These are the HCPCS descriptions
- At this time, each institution (e.g., civilian institution, such as the Mayo Clinic can have one way, and the Rochester Clinic another) needs to differentiate the various levels
- The MHS needs to determine how it differentiates the levels

Emergency Department Institutional

- Why nurse/technician face-to-face with patient minutes?
  - Procedures already include both professional and institutional components
  - Facilities are fixed costs, they stay the same regardless of volume
  - Supplies are usually included in the procedure (e.g., casting supplies)
  - Nurse/technician time is a variable

Emergency Department Institutional

- How the MHS will differentiate:
  - Minutes of face-to-face nurse/technician interaction with the patient, which is not included in a procedure code
  - For example,
    - If a privileged provider gives an injection and codes the injection, the nurse/technician time is included in the practice expense of the provider coded procedure
  - On the other hand,
    - If the provider orders an injection by the nurse/technician, then the procedure would not be separately coded and the nurse/technician time would be used to determine of the level of the institutional component

Emergency Department Institutional

HCPCS Narrative

- Institutional component of a hospital emergency visit provided in a department or facility of the hospital
- The department or facility must meet at least one of the following requirements:
  1. It is licensed by the state in which it is located under applicable state law as an emergency room or emergency department
  2. It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment
  3. During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment

Emergency Department Institutional

- MHS method of determining different levels. Times are approximate based on documentation
  - **G0380 Level 1. 1-15 minutes of face-to-face** Nurse/technician interaction with the patient, which is not included in a procedure code
  - **G0381 Level 2. 16-30 minutes of face-to-face** Nurse/technician interaction with the patient, which is not included in a procedure code
  - **G0382 Level 3. 31-45 minutes of face-to-face** Nurse/technician interaction with the patient, which is not included in a procedure code
  - **G0383 Level 4. 46-60 minutes of face-to-face** Nurse/technician interaction with the patient, which is not included in a procedure code
  - **G0384 Level 5. More than 60 minutes of face-to-face** Nurse/technician interaction with the patient, which is not included in a procedure code

Emergency Department Institutional

- Nurse/Technician time based on documentation
  - Did technician adjust crutches and teach the patient how to properly use the crutches? Did the technician just adjust the crutches as the patient had used crutches previously? This would only apply if there was no procedure (e.g., no strapping or casting). If there is a codable procedure, the nurse/technician time is included in that code's institutional component
  - Did the technician constantly monitor the patient (e.g., vital signs documented every few minutes) or check the patient periodically (e.g., times on notes indicate patient still applying pressure on his wound with minor bleeding documented every 20 minutes)

Emergency Department Institutional

- When coding,
  - The professional component will be entered in the E&M field
  - The institutional will be the last procedure, unless there are more than 3 procedures, in which case the institutional will be the 4th procedure, linked to the diagnosis(es) that caused the face-to-face time
    - If the only face-to-face time is check-in and check-out, then the diagnosis that caused the patient to come to the Emergency Department will be linked to the G0380/1/2/3/4
  - No need to list nurse/technician as additional provider

Emergency Department Institutional

- NOTE: When patient is transported, which is not included in the procedure, include the time the technician spent transporting the patient. For instance, if the patient is taken to radiology, the operating room or the ward on a gurney or in a wheel chair, add the time WITH the patient. Do not add the time the technician took to walk back to the Emergency Department without the patient

Approximately 671 New Codes

- 13 – A codes (6 deleted)
- 10 – C codes (18 deleted)
- 22 – D Codes (2 deleted)
- 23 – E Codes (2 deleted)
- 11 – G Codes
- 2 – H Codes
- 165 – “HEDIS” type (60 – CPT Category II; 105 – HCPCS)
- 81 – HCPCS Oncology
- 114 –Durable Medical Equipment
- 34 – J-codes

Other Groups of Codes Expanded/Changed

- Substance Abuse Rehabilitation Center

H0049		ALCOHOL/DRUG SCREENING
H0050		ALCOHOL/DRUG SERVICE 15 MIN

Ophthalmology

- 92025 Computerized corneal topography, unilateral or bilateral, with interpretation and report
  - Intended to be reported when topography is not performed in conjunction with keratoplasty procedures (65710, 65730, 65750, and 65755)
  - Procedure previously reportable as S0820 – Computerized corneal topography, unilateral (had .35 MHS RVUs)

Sneaky Guys

- CPT/HCPCS codes can be updated multiple times during the year
- CCE has a different code set than the MHS code set
- Not all coding books are the same; for instance, the Ingenix CPT code book announced codes 1 July 2006, which was too late for the AMA CPT 2007 book
- A bunch are not in the Ingenix CPT book
- In the MHS master list under line 680 “Errata Add”
- BOTTOM LINE: Category II and III so no big deal – use them if you feel like it (well, the category III you have to use if they apply…)

Category II Codes – Diabetes

- There could be category I codes or HCPCS codes that also meet the indication
  - **2028F – Performance of a foot examination that includes visual examination of the foot, sensory examination with monofilament, and pulse exam (need all three components)** (New this year!!!)
  - G0245 – Initial E&M of DM patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS)
  - G0246 – Follow-up E&M of DM patient with LOPS
  - G0247 – Routine foot care of DM patient with LOPS

Fecal Occult Blood Test

- G0107 Deleted, now use 82270
  - Medicare has announced its plan to retire fecal-occult blood test (FOBT) code **G0107** on 1 Jan 2007 in an effort to enhance clarity in FOBT codes
  - Medicare wants you to use CPT code **82270** instead

Quiz

- List the code groups that will have the greatest effect on MHS coding
- Indicate why various codes were added, deleted, and changed